HOW TO OBJECT TO YOUR SUMMARY RATING

This form should be completed if you believe your Permanent Disability Summary Rating Determination is incorrect.

Complete the form, following the instructions carefully. Note there are only four (4) reasons when you may file this request. If your reasons do not fall within these four, your petition will be denied and your case will be delayed. Disagreement with the Qualified Medical Evaluator's or Primary Treating Physician's conclusions is not a reason to object to the Summary Rating.

You must submit your request within thirty (30) days of receipt of the rating.

Attach to the form copies of:

- 1. The Summary Rating Determination
- 2. The Qualified Medical Evaluator's or Primary Treating Physician's report
- 3. Any other information that supports your request.

Send the originals of your request to:

Administrative Director
Division of Workers' Compensation
P.O. Box 420603
San Francisco, CA 94142
Attn: Summary Rating Reconsideration

It is important you complete the Proof of Service at the bottom of the form. Instructions are on the back. A copy must be sent to the insurance company.

Keep a copy for your records.

If you need help you may call an Information and Assistance Office. The local I&A phone numbers are listed on the back of this guide.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations which are different than presented here.

WORKERS' COMPENSATION APPEALS BOARD DISTRICT OFFICES

1661 N. Raymond Avenue Ste. 200 (714) 738-4038 1880 North Main Street, 1st Floor Information & Assistance Unit (408) 443-3058 Information & Assistance Unit BAKERSFIELD, 93309 1800 30th Street, Rm.100 Information & Assistance Unit (661) 395-2514 SAN BERNARDINO, 92401-1888 464 West Third Street, Ste. 239 Information & Assistance Unit (909) 383-4522 Information & Assistance Unit EUREKA, 95501-0421 100 "H* Street, Rm. 2011 Information & Assistance Unit (707) 441-5723 Information & Assistance Unit (619) 525-4589 Information & Assistance Unit FRESNO, 93721-2280 2550 Manposa Street, Rm. 4078 Information & Assistance Unit (559) 445-5355 SAN FRANCISCO (DISTRICT OFFICE), 94102 455 Golden Gate Ave., 2nd Floor Information & Assistance Unit (415) 703-5020 Information & Assistance Unit GOLETA, 93117 6755 Hollister Avenue Information & Assistance Unit (805) 968-4158 100 Paseo de San Antonio, Rm. 223 Information & Assistance Unit (408) 277-1292 Information & Assistance Unit GROVER BEACH, 93433-2261 1562 Grand Avenue Information & Assistance Unit (805) 481-3296 SANTA ANA, 92701-4080 22 Cviv. Center Plaza, Ste. 451 Information & Assistance Unit (714) 558-4597 Infor	ANAHEIM, 92801		SALINAS, 93906	
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SACRAMENTO, 95825				
2424 Arden Way, Ste. 230 (916) 263-2741 Information & Assistance Unit		(916) 263-2741		

REQUEST FOR RECONSIDERATION OF SUMMARY RATING TO THE ADMINISTRATIVE DIRECTOR

This form may be used by an unrepresented employee or his or her employer to request that the Administrative Director determine whether a permanent disability rating performed by the Office of Benefit Determination should be reconsidered pursuant to Labor Code Section 4061(k).

A request for reconsideration may be granted if it is shown that the Qualified Medical Evaluator (QME) has failed to address all issues, failed to completely address issues, failed to follow the procedures promulgated by the Industrial Medical Council (IMC), or if the rating was incorrectly calculated. This procedure is applicable only to injuries occurring on or after 1/1/91. Please verify that you sent a copy of this request to the other party (employee or claims administrator) by filling out the proof of service below after reading the instructions on the reverse side.

This request must be submitted within thirty (30) days of receipt of the rating.

SEND TO: Administrative Director

Division of Workers' Compensation 45 Fremont Street, 31st Floor San Francisco, CA 94105

Attn: Summary Rating Reconsideration

INCLUDE: (1) This completed form;

(2) A copy of the Summary Rating(3) A copy of the Qualified Medical

Evaluation (QME) Report

(4) Other information supporting the request

		Disability Evaluation	
Employee Name:		Unit File Number: Employer/Insurer	
Employee Address:		Claim Number:	
Employer/Adjusting Agency		Employee's Social Security Number:	
Employer/Adjusting Agency Address:		Date of Injury:	
REASON(S)	FOR REQUEST: (Check reason and	l explain below. Attach	additional sheets if necessary.)
[] QME failed	to address all issues [] QME failed to con	npletely address issues
[] IMC proced	ures not followed by QME [] Rating was incorre	ctly calculated
Explanation:			
Reconsideration of S	Summary Rating is being requested by: _		
		(Injured worker/Emp	loyer/Claims Adjusting Agency)
	PROOF OF SE	ERVICE BY MAIL	
(Instructions on Revers	e)I served a copy of this Request for Rec	consideration of Summary R	ating on
(date)		•	
, c 1	cclaims administrator)	(address)	by placing
(name at employee ar			
a true copy enclosed	in a sealed envelope with postage fully prof the State of California that the foregoing	repaid, and deposited in th	e U.S. Mail. I declare under penalty o

REQUEST FOR RECONSIDERATION OF SUMMARY RATING TO THE ADMINISTRATIVE DIRECTOR

INSTRUCTIONS FOR COMPLETING THE PROOF OF SERVICE BY MAIL

Complete the <u>Proof of Service by Mail</u> on the reverse side as follows:

	<u>1</u>	PROOF OF SERVICE BY MAI	<u>L</u> (SAMPLE)			
On _	#1	I served a copy of this Red	quest for Reconsidera	tion of Summary Rating on			
	(date) #2	at	#3	by placing			
a true	copy enclosed in a s	atatatams administrator) sealed envelope with postage fully the laws of the State of California	prepaid, and deposi-	ed in the U.S. Mail. I declare und			
		Signature _	#4				
1)	List on line #1 the	date on which you mailed this fo	rm				
2)	If you are the Injured Employee, list on line #2 the name of the Insurance Carrier of Claims Adjusting Agency handling your case. If you are the Insurance Carrier/Claims Adjusting Agency, list the name of the Injured Employee						
3)	List on line #3 the you listed on line	mailing address for the Insurance Carrier/Claims Adjusting Agency or Injured Employee 2.					
4)	Sign your name on 1	ine #4					